

Perry 1

Initiating Events



Significance: Jun 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Procedures While Paralleling to the Grid

The inspectors identified a Non-Cited Violation of Technical Specification 5.4.1.a for failure to follow procedures while paralleling to the grid. Licensee personnel failed to verify synchronization prior to closure of a main generator output breaker. The finding was of very low safety significance because the event did not effect the likelihood of a loss of coolant accident, contribute to both a scram and loss of mitigation equipment, nor increase the likelihood of flooding or fire.

Inspection Report# : [2002005\(pdf\)](#)



Significance: Feb 17, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Remove Temporary Lights From the Reactor Water Cleanup Heat Exchanger Room After One Cycle

The inspectors identified a Non-Cited Violation of 10CFR50 Appendix B, Criterion III, for failure to remove temporary lighting from the reactor water cleanup room after one-cycle as required by Field Clarification Request. The lights eventually degraded and caught fire. The finding was greater than minor because it had an actual impact of causing a small fire in a room containing plant operating, fire protection and safety-related equipment. The event was of very low safety significance because, although the finding contributed to the likelihood of an external event initiator, no equipment was damaged from the event.

Inspection Report# : [2001016\(pdf\)](#)

Mitigating Systems

Significance: TBD Dec 28, 2002

Identified By: Self Disclosing

Item Type: AV Apparent Violation

HIGH PRESSURE CORE SPRAY PUMP FAILURE TO START

To Be Determined. An apparent self-revealed violation of technical specification (TS) 5.4 occurred when the High Pressure Core Spray (HPCS) pump failed to start during a surveillance test of the HPCS room cooler. Troubleshooting by the licensee revealed that contacts in the breaker enclosure that provide a close permissive signal were misaligned and prevented starting of the HPCS pump. Since the last breaker replacement, the licensee had performed one post-maintenance test and two inspections of the circuit breaker that would have detected the misalignment of contacts had the procedure been properly followed. The finding is identified as Apparent Violation (AV) 50-440/02-08-02. The NRC assessed this finding through phase 3 of the SDP and made a preliminary determination that it is an issue with some increased importance to safety. (Section 4OA3.3)

Inspection Report# : [2002008\(pdf\)](#)



Significance: Sep 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO DEMONSTRATE EFFECTIVE MAINTENANCE FOR THE ROD CONTROL AND INFORMATION SYSTEM

Green. The inspectors identified a NCV of 10 CFR 50.65 (a)(2) for the licensee's failure to demonstrate that the performance of the rod control and information system (RCIS) was being effectively controlled through the performance of appropriate maintenance. The licensee's failure to consider the rod insertion function of the RCIS when evaluating system performance was determined to be the cause of the error. The issue was evaluated as having very low risk significance (Green) since, although the mitigation system cornerstone was affected in that reactivity control was degraded by loss of a RCIS safety, no actual loss rod insertion ability occurred due to other methods being available. (Section 1R12)

Inspection Report# : [2002006\(pdf\)](#)

G**Significance:** Sep 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO FOLLOW PROCEDURES FOR IMPROPERLY FUNCTIONING CONTROL ROOM INDICATIONS

Green. The inspectors identified a NCV of Technical Specification (TS) 5.4 for the licensee's failure to follow procedures regarding tagging of improperly reading equipment. The primary cause was the crosscutting issue of human performance since the technicians and operators failed to recognize out-of-specification data in the partially completed surveillance indicated equipment degradation. The finding was more than minor because an indication used by control room personnel for vessel level did not read correctly and under other circumstances a failure of a control function could have been overlooked. The finding was of low safety significance because no loss of automatic protective functions occurred and other indications of vessel level were available to operators. (Section 1R22)

Inspection Report# : [2002006\(pdf\)](#)G**Significance:** Jun 30, 2002

Identified By: NRC

Item Type: FIN Finding

Inadequate Posting of Protected Equipment During Risk Significant Maintenance Activities

The inspectors identified a licensee performance deficiency associated with the protection of Emergency Service Water 'B' and 'C' trains during a Division 1 ('A' train) outage. Although the 'B' and 'C' pumps were posted as protected equipment, the motor control centers were not. The finding was of very low safety significance because, although the inspectors observed considerable work activities in the immediate vicinity of the motor control centers, the mitigation systems remained operable.

Inspection Report# : [2002005\(pdf\)](#)G**Significance:** Jun 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Correct Procedure Deficiency Involving Surveillance Test Equipment

A Non-Cited Violation of 10 CFR 50 Appendix B, Criterion XVI for failure to ensure conditions adverse to quality are corrected. The licensee failed to correct a previously identified procedure deficiency associated with test equipment used to test the level 3 and level 8 Reactor Protection System and Residual Heat Removal shutdown insulation functions. As a result, during the April 2002 performance of the 24-month surveillance, the licensee experienced a similar failure. The finding was of very low safety significance because, although the procedure deficiency had an actual impact causing the loss of one channel of level protective functions for several hours, no actual loss of safety function occurred.

Inspection Report# : [2002005\(pdf\)](#)G**Significance:** Jun 28, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Incorporate Instrument Uncertainty Into Design Basis Calculations and Procedures

(GREEN) The inspection team identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control." Specifically, the emergency service water system forebay temperature limit was not properly incorporated into plant procedures. Specifically, the plant procedures did not include margin to account for temperature instrument uncertainty. As a result, the emergency service water forebay temperature could have exceeded its design limit during plant operation without being detected. The finding was greater than minor because it impacted the ability of the emergency service water system to perform its design basis function and lake temperatures had previously approached the design basis limit. The finding was of low safety significance because the emergency service water system was operable. (Section 1R21.1).

Inspection Report# : [2002004\(pdf\)](#)G**Significance:** Feb 17, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Procedures for Maintaining Electrical Separation Criteria

The inspectors identified a Non-Cited Violation of 10CFR50 Appendix B, Criterion V, for failing to follow plant procedures to maintain electrical separation between Class 1E and Non-class 1E cables and conduits. The finding was greater than minor because if left uncorrected, routing the extension cords near safety-related power cables increased the likelihood of rendering multiple trains of safety-related equipment inoperable given a fire from those temporary cables. Further, the multiple examples of violating the electrical separation criteria indicated a lack of plant personnel knowledge of the requirement. The finding was of low safety significance because an actual fire had not occurred that

rendered the associated equipment unavailable.

Inspection Report# : [2001016\(pdf\)](#)

Barrier Integrity



Significance: Dec 28, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM TECHNICAL SPECIFICATION REQUIRED TESTING

Green. The inspectors identified a violation of TS surveillance requirement (SR) 3.6.1.9.1 in that the licensee failed to perform TS required surveillance testing and appropriate post-maintenance testing (PMT) following packing adjustment of a main steam shutoff valve. SR 3.6.1.9.1 specified that the licensee verify isolation times of main steam shutoff valves at a frequency in accordance with the Inservice Testing Program. The Inservice Testing Program specifically stated that following adjustment of stem packing, stroke time testing will be performed. Contrary to this requirement, no stroke time testing was performed on the valve. The inspectors also noted that the condition was further aggravated by the licensee's use of an operability determination to declare the valve operable once the missed PMT was initially identified. The licensee failed to recognize the TS compliance aspect until prompted, repeatedly, by the inspectors. The inspectors determined that the finding was more than minor because the failure to perform PMT on a safety related component could reasonably be viewed as a precursor to a significant event. The finding was of very low risk significance because, although the barrier integrity cornerstone was affected in that containment systems capability was not demonstrated through TS required surveillance testing, subsequent testing demonstrated that the system would have performed its intended safety function. (Section 1R19)

Inspection Report# : [2002008\(pdf\)](#)

Emergency Preparedness



Significance: Apr 12, 2002

Identified By: NRC

Item Type: FIN Finding

Inadequate critique of certain exercise controller and participant actions in the Operations Support Center

The licensee's exercise critique did not identify inappropriate exercise controller interactions with some participants who were involved in Operations Support Center (OSC) activities. Specifically, on multiple occasions various participants were given information by a licensee exercise controller during the exercise before they had opportunities to demonstrate how they would either earn such information or how they could identify and correct mis-information. Also, the licensee's critique did not identify a few instances of exercise participants' failure to implement adequate protective measures associated with OSC activities. The NRC has determined that the above finding on the inadequate critique of certain OSC controller and exercise participants' performances was of very low safety significance (Green). In accordance with NRC's Enforcement Policy, the critique issue is not a violation of NRC requirements since it was associated with an exercise, rather than with an actual emergency response.

Inspection Report# : [2002003\(pdf\)](#)

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

Last modified : March 25, 2003